Statement For the Record
of the
Hearing of the
House Energy and Commerce Committee
Subcommittee on Health
On
"Medicare Physician Payment:
2007 and Beyond."

Testimony of the American College of Physicians

September 28, 2006

Thank you, Chairman Deal and Ranking Member Brown:

I am William E. Golden, MD, FACP, chair of the Board of Regents of the American College of Physicians. The 120,000 internal medicine physicians and medical student members of the American College of Physicians congratulate Chairman Barton and the members of the House Energy and Commerce Subcommittee on Health for convening today's hearing on "Medicare Physician Payment: 2007 and Beyond."

The American College of Physicians believes that it is essential that Congress take immediate action to reform the dysfunctional Medicare physician payment system. Medicare payments are dysfunctional because they reward high volume, episodic, and fragmented care that undervalues the relationships between physicians and their patient and, as a result, often does not produce desired outcomes. Instead, we need a payment system that is centered on patients' needs, one that recognizes the value of a patient's relationship with their personal physician, and one that provides incentives for physicians

to engage in continuous quality improvement and measurement supported by health information technology.

As a general internist in Little Rock, Arkansas and Professor of Medicine and Public Health at the University of Arkansas for Medical Sciences, I have personal experience with the challenges that primary care physicians face in taking care of Medicare patients under a payment system that systematically undermines and devalues the relationships elderly patients have with their personal physicians.

My perspective on pay-for-reporting is based on decades of experience with quality improvement at both the national and state level. I am vice president for quality improvement for the Arkansas Foundation for Medical Care, the state's Quality Improvement Organization (QIO), and I serve on the Steering Committee for the AMA/Physician Consortium for Performance Improvement (PCPI). I am a former member of the Board of Directors of the National Quality Forum, and a past president of the American Health Quality Association.

Creating a Pathway for Physician Payment Reform

The College urges Congress to enact a step-by-step plan that stabilizes physician payments in the immediate term, while creating the building blocks for longer term reforms.

Over the past several weeks, the College's Washington staff has had the privilege of working with House Energy and Commerce Committee staff to provide

recommendations on immediate and longer-term relief from Medicare cuts while taking important first steps toward creating a better payment system for Medicare patients. I congratulate Chairman Barton and the committee staff for opening discussions on draft legislation.

I also wish to thank Dr. Burgess, who has made an enormous contribution to creating a better payment system by introducing H.R. 5866, the "Medicare Physician Payment Reform and Quality Improvement Act of 2006." The College also appreciates Ranking Member Dingell's commitment to replacing the sustainable growth rate (SGR) and reforming Medicare physician payments, as evidenced by his introduction of H.R. 5916, the "Patients' Access to Physicians Act of 2006." It is encouraging to see that there is broad bipartisan support for halting the pending Medicare cuts and instituting other needed reforms in Medicare payment policies.

Our understanding is that Chairman Barton's discussion draft includes the following key elements:

1. It replaces the 2007 SGR cuts with a positive update for all physicians.
2. It provides three years of stable, positive and predictable updates for all physicians.
3. It treats any increased expenditures resulting from such stable and positive updates as a "change in law and regulation" that will be reflected in Medicare baseline spending, reducing the eventual costs of repealing the SGR.
4. It begins a voluntary and non-punitive pay-for-reporting program in 2008, with multiple pathways for physicians to meet the reporting requirements to qualify for a higher (positive) update.
5. It requires that the Secretary of HHS report to Congress on a strategic and implementation plan for eliminating the SGR.
6. It institutes a Medicare demonstration of the patient-centered medical home, a new model for organizing, financing, and reimbursing care of patients with

chronic diseases that has enormous potential for improving quality and reducing costs.

I am pleased to share the College's views on each of these elements.

Providing Positive, Predictable and Stable Updates

The College believes that it is imperative Congress enact legislation to replace the 5.1 percent SGR cut scheduled to occur on January 1, 2007 with positive updates. Halting the 2007 cut and replacing it with a positive update must be Congress's top priority, because it will be impossible to move forward on other needed payment reforms in an environment when physicians are facing another deep cut.

To this end, we urge the members of the House Energy and Commerce Committee to work with your colleagues on the House Ways and Means Committee, the House leadership, and your colleagues on the Senate Finance Committee to reach agreement on legislation to halt the 2007 cut and replace it with positive updates. It is understandable that there are different perspectives on the amount of the 2007 update, the mechanisms to pay for it, and subsequent steps to achieve reform of the payment system, but these should not stand in the way of halting the 2007 cuts. If action to halt the cuts and replace them with positive updates is not taken before the House of Representative recesses later this week, then it will be essential that an agreement be reached before Congress returns for a post-election "lame duck" session so that immediate action can be taken at that time.

The College believes that it is preferable to provide several years of predictable, stable and positive updates for all physicians, as Chairman Barton's discussion draft would do, rather than providing only one year of relief from the SGR cuts. By setting the updates in statute for the next three years, the Chairman's discussion draft will provide physicians with the sense of certainty and financial stability needed for them to begin participating in programs to improve, measure and report their performance.

Three years of positive, predictable and stable updates will also give Congress the time needed to explore alternatives to the SGR and to assess the impact on quality and cost of physician participation in voluntary programs and demonstration projects to improve quality and manage the care of patients with multiple chronic diseases. By comparison, providing only one year of guaranteed positive updates, with no assurance that there will be positive updates in 2008--and with the prospect of deep cuts if the update reverts to the SGR formula--would create great uncertainty in physicians' minds on whether they can afford to invest in the health information technology and other tools needed to effectively assess, measure and improve on the care provided to Medicare patients.

As much as the College prefers that Congress stabilize physician payments for several years, we believe that even one year of stable, positive and predictable updates is clearly better than allowing the SGR cut to go into effect.

Chairman Barton's discussion draft would provide all physicians with a 0.5 percent update in 2007. In 2008 and 2009, the guaranteed updates will also be 0.5 percent for

those physicians who do not report on quality measures, and an additional 0.25 percent bonus payment for physicians who voluntarily select from a menu of specified pathways to report on quality or structural measures or improve care of patients with chronic diseases.

We are appreciative that Chairman Barton wants to assure that all physicians will get positive updates, and we very much agree that pay-for-reporting should result in positive incentives for participation in such programs, not punitive cuts for those who cannot participate. *We encourage the Committee to consider increasing the update to at least 1 percent each year, and to provide a greater reporting incentive—e.g. another 1 or 2 percent—for physicians who voluntarily participate in one or more of the pathways.* Providing updates of only 0.5 percent per year, after five years of updates that have not kept pace with inflation, would still leave many physicians in the precarious position of trying to deliver good care to Medicare patients at a time when reimbursement will continue to fall further and further behind their actual costs.

The College is also pleased that the positive updates in Chairman Barton's discussion draft would be considered a change in "law and regulation" and incorporated into calculations of Medicare baseline spending, thereby reducing the costs of repealing the SGR. Alternative financing mechanisms have been suggested that would treat the positive updates as one year bonuses that would not affect baseline spending, the result of which would be to revert to the cuts that would have resulted from the SGR. For instance, if a one year bonus in 2007 was not included as baseline spending and payments were to

revert to the SGR in 2008, physicians would be facing a combined 10-13 percent cut in 2008 (the equivalent of the 5.1 percent cut in 2007 combined with another SGR cut of five or six percent cut in 2008). For this reason, we believe that it is preferable to bring down the costs of eliminating the SGR, as Chairman Barton proposes, rather than the alternative of treating the higher updates as "bonus" payments not accounted for as Medicare baseline spending.

Creating Incentives for Performance Measurement and Improvement

Through my work with the Arkansas Foundation for Medical Care, I have found that physicians welcome voluntary programs that provide them with meaningful and actionable information and assistance to help them improve quality. To succeed in such programs, physicians must acquire tools to assist them in assessing, measuring and improving care and to devote a considerable amount of their own and their staff's time toward the programs**.**

Providing a small bonus of only 0.25 percent is unlikely to be sufficient to cover the costs physicians will incur in reporting on the measures. For many physicians in small practices, the benefit of participating in the quality reporting programs will not be worth the substantial increase in their practice expenses and time required.

Congress should also allow sufficient time for physicians to identify the clinical and structural measures that are most applicable to their specialty or patient population and to institute the practice changes needed to report on such measures. Although we believe

that many physicians could begin reporting on a core set of structural or clinical measures by the end of 2007, a "ramp up" year would allow for more clinical measures to be developed, validated and implemented and for more physicians to acquire the necessary tools and health information technologies associated with most structural measures.

If Medicare pay-for-reporting begins in 2007, we recommend that it start with a menu of structural or clinical measures that most physicians report on, from which physicians could choose to report on the three to five measures most applicable to their specialty and patient population. The data collection process should be structured in such a way to be time efficient and not overly burdensome on the physician practice.

The College also supports the idea of offering physicians several different options for qualifying for the pay-for-reporting bonuses payments, as Chairman Barton's discussion draft proposes. We are pleased that physicians would be given the option of reporting on evidence-based clinical measures, or on structural measures that demonstrate they are acquiring the tools and technologies needed to support quality improvement and patient safety.

The College recommends that any legislation to initiate a Medicare pay for reporting program should recognize and support the complementary efforts of the AMA/PCPI the National Quality Forum, and the AQA. The Secretary should be required to use measures that are developed through these processes and should not be permitted to substitute different measures.

Any clinical measures that apply to physicians should be developed by the AMA/PCPI, a multi-specialty consensus process that is making remarkable progress in developing measures for all specialties, having completed work on 150 measures in the past year alone. Once developed by the consortium, they should be submitted to the National Quality Forum for validation based on review of the scientific evidence behind the measure. Finally, the measures should be reviewed by the AQA, a multi-specialty stakeholder organization that works to identify measures for implementation that will be applied consistently and uniformly across different performance improvement programs, regardless of the payer administering the program. Such uniformity is essential so that physicians are not faced with reporting on different and conflicting measures for the same clinical condition for different reporting programs. The AQA also looks at the feasibility of implementing a measure. For instance, the AQA will consider if it is administratively practical for physicians to collect the data needed to report on a measure.

Structural measures should also be based on evidence that they can contribute to improvements in patient safety and quality improvements in physician offices. Structural measures that are used in private sector pay-for-reporting programs, such as the Physician Practice Connection modules developed by NCQA and used in the Bridges to Excellence programs, should be considered as a starting point for identifying structural measures for the Medicare program.

Chairman Barton's discussion draft would also require that physicians participate in a utilization management program administered by a state or regional QIO or state medical society in order to qualify for the reporting bonus. The College suggests that participation in such a program should be one of the *options* to qualify for the bonus payments—along with reporting on clinical or structural measures or participating in a demonstration project on the patient centered medical home—rather than being required of all physicians in order to qualify for the performance bonus. The legislation should also specify that the program is intended solely to provide physicians with confidential and comparative information on how their utilization compares with their peers, and will not be used for claims audits, denials or public reporting.

HHS Report on Alternatives to the SGR

Any legislation to provide predictable, positive and stable updates must have as its goal the complete elimination of the SGR.

We understand that the price of repeal is very high, but we believe that the price of maintaining a flawed SRG formula is even higher. If the SGR is maintained, Medicare patients will suffer reduced access, as established physicians are forced to limit how many Medicare patients they will see and medical students and young physicians decide not to enter the two primary care specialties--internal and family medicine--that most Medicare patients rely on for their medical care.

Short of repeal, we believe that legislation should at least create a process that will lead to a recommendation and decision on repeal of the SGR. We are pleased that Chairman Barton's discussion draft requires that the Secretary of HHS provide an implementation and strategic plan repealing the SGR, but urge Congress to act before then and replace it with a system that provides positive, predictable and fair updates to all physicians that reflect increases in practice expenses.

Pilot Program of the Patient-Centered Medical Home

The College is extremely pleased that Chairman Barton's discussion draft includes a demonstration project on the patient-centered medical home. The premise behind the patient-centered medical home is that patients who have an ongoing relationship with a personal physician, practicing in systems of care centered on patients' needs, will get better care at lower cost.

Under the Chairman's discussion draft, participation in the demonstration project would be one pathway for physicians to qualify for the reporting bonus payments, and qualified practices would also be eligible for a new payment methodology that covers the practice expenses and physician and non-physician work associated with care coordination. The discussion draft outlines a process for practices to qualify for this different reimbursement model based on demonstration that they have the ability to provide patient-centered services for patients with chronic diseases. It also gives the Secretary

authority to reduce co-payments or deductibles for Medicare patients who choose to receive care through a patient centered medical home.

We believe that this model has enormous potential to improve quality and lower costs, principally through reduced hospitalizations, for patients with multiple chronic diseases.

The key attributes of the patient-centered medical home, as described in a joint statement of principles from the ACP and the American Academy of Family Physicians, are attached. **[See Appendix A]**

Achieving Long Term Reform

By including the patient-centered medical home in the discussion draft, Chairman Barton is creating the foundation for a long-term reform of Medicare physician payments that recognizes the value of care that is coordinated and managed by a personal physician in partnership with a patient. A recent study published in Health Affairs (Thorpe, Kenneth and Howard, David, "*The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity*," 22 August 2006) concluded that *all* of Medicare's cost increases in recent years are due to the increased numbers of beneficiaries with multiple chronic diseases. The patient-centered medical home demonstration will create a pathway for developing an entirely new financing and delivery model that can achieve better care for such patients at lower cost.

The pay-for-reporting provisions in Chairman Barton's discussion draft will also allow Medicare to gain experience with the potential of performance measurement and improvement, linked to financial incentives, to improve outcomes and potentially, achieve cost savings. We recommend, however, that during the three-year transition period envisioned in Chairman Barton's discussion draft, Congress move toward creating a new system that fundamentally restructures the physician payment system, including providing a means to fund pay-for-performance programs that have the greatest potential to improve quality and reduce costs.

First, the SGR should be replaced by a system that allocates a set portion of Medicare spending towards providing an annual update to physicians based on inflation.

Second, Congress should set aside an additional amount to fund a performance improvement pool. This pool would fund physician-directed programs that have been shown to have the potential to improve care and, potentially, achieve cost savings.

Third, Congress should specify that a portion of savings associated with reductions in spending in other parts of Medicare, which are attributable to quality improvement programs funded out of the physicians' quality improvement pool, would be redirected back to the pool. Such savings would include: reductions in Part A expenses due to avoidable hospital admissions related to improved care in the ambulatory setting and savings resulting from non-physician Part B expenses (such as reductions in avoidable durable medical equipment expenses or laboratory testing resulting from better

management in the ambulatory setting that results in fewer complications).

Fourth, the performance improvement pool should include prioritized funding for pay-for-performance programs that use measures having the greatest potential impact on improving quality and reducing costs. We believe that robust evidence-based clinical measures for chronic disease will have a greater impact on quality and cost rather than simple and basic cross-cutting measures broadly applicable to all physicians.

Fifth, performance-based payments funded out of the pool should pay individual physicians on a weighted basis related to performance:

Reporting on high impact measures should receive higher performance payments than lower impact measures;

The weighted performance payments should acknowledge that reporting on a larger number of robust quality measures typically will require a greater commitment of time and resources than reporting on one or two basic measures;

The weighted performance payments should take into account physician time and practice expenses associated with reporting on such measures; and

The weighted performance payments should also provide incentives for physicians who improve their own performance as well as those who meet defined quality thresholds based on the measures;

The weighted performance payments should allow individual physicians to benefit from reductions in spending in other parts of Medicare attributable to their performance improvement efforts.

Particularly for chronic disease conditions, reporting on measures will require a substantial investment of physician time and resources to implement the technologies needed to coordinate care effectively, to follow-up with patients on self-management plans, to organize care by other health care professionals, and to measure and

report on quality. These differences should be recognized in the weighted pay-for-performance payments.

During the transition period, Congress should also enact legislation to make the elements of the patient-centered medical home a permanent part of the Medicare program, rather than limiting it to a demonstration project. This should include enacting a new reimbursement model for patients with chronic diseases that recognizes and supports the value of care managed and coordinated by a personal physician in partnership with the patient.

Conclusion

The College commends Chairman Barton and the members of the House Energy and Commerce Subcommittee on Health for holding this important hearing.

We believe that Congress should embrace the opportunity to pass legislation this year that will transition the dysfunctional Medicare payment policies to a bold new framework that will improve quality and lower costs by aligning incentives with the needs of patients. This transition should:

1. Replace the 2007 SGR cuts with a positive update for all physicians;
2. Provide multi-year stable, positive and predictable updates for all physicians;
3. Treat any increased expenditures resulting from such stable and positive updates /as a "change in law and regulation" that will be reflected in Medicare baseline spending, reducing the eventual costs of repealing the SGR;

4. Begin a voluntary and non-punitive pay-for-reporting program in 2008, with multiple pathways for physicians to meet the reporting requirements to qualify for a higher (positive) update. This should begin with "high impact" measures that have been approved by the NQF and AQA and that reimburses physicians on a weighted basis related to the number, impact, and commitment of resources associated with the measures being reported;

5. Require the Secretary of Health and Human Services report to Congress on a strategic and implementation plan for eliminating the SGR;
6. Institute a Medicare demonstration of the patient-centered medical home, a new model for organizing, financing, and reimbursing care of patients with chronic diseases that has enormous potential for improving quality and reducing costs;

7. Allow physicians to share in system-wide savings in other parts of Medicare that can be attributed to their participation in performance measurement and improvement.

SUMMARY

ACP believes that Congress should embrace the opportunity to pass legislation this year that will transition the dysfunctional Medicare payment policies to a bold new framework that will ultimately improve quality and lower costs by aligning incentives with the need of patients. We believe the elements of this transition should do the following:

1. Replace the 2007 SGR cuts with a positive update for all physicians;

2. Provide a multi-year stable, positive and predictable updates for all physicians;

3. Treat any increased expenditures resulting from such stable and positive updates as a "change in law and regulation" that will be reflected in Medicare baseline spending, reducing the eventual costs of repealing the SGR;

4. Begin a voluntary and non-punitive pay-for-reporting program in 2008, with multiple pathways for physicians to meet the reporting requirements to qualify for a higher (positive) update. This should begin with "high impact" measures that have been approved by the NQF and AQA and that reimburses physicians on a weighted basis related to the number, impact, and commitment of resources associated with the measures being reported;

5. Require the Secretary of Health and Human Services report to Congress on a strategic and implementation plan for eliminating the SGR;

6. Institute a Medicare demonstration of the patient-centered medical home, a new model for organizing, financing, and reimbursing care of patients with chronic diseases that has enormous potential for improving quality and reducing costs; and

7. Allow physicians to share in system-wide savings in other parts of Medicare that can be attributed to their participation in performance measurement and improvement.

APPENDIX A

AAFP and ACP recently adopted a joint statement of principles that describes the key attributes of a patient-centered medical home:

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician- directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care; chronic care; preventive services; end of life care.

Care is coordinated and/or integrated across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants and other components of the complex health care system), facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.

Quality and safety are hallmarks of the medical home:

- Evidence-based medicine and clinical decision-support tools guide decision making;
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement;
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met;
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication;
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.

Enhanced access to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management;

- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;

- It should support adoption and use of health information technology for quality improvement;

- It should support provision of enhanced communication access, such as secure e-mail and telephone consultation;

- It should recognize the value of physician work associated with remote monitoring of clinical data using technology;

- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits);

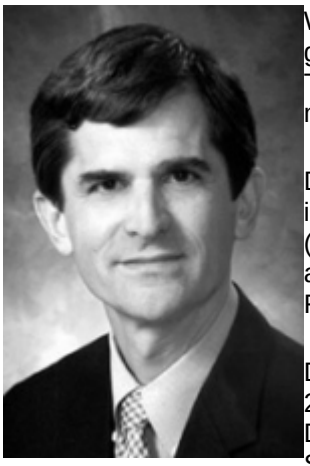
- It should recognize case mix differences in the patient population being treated within the practice;

- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting;

- It should allow for additional payments for achieving measurable and continuous quality improvements.

Such payments could be organized around a "global fee" for care management services that encompass the key attributes of the patient-centered medical home.

Chair, Board of Regents, 2006-2007 - William E. Golden, MD, FACP



William E. Golden, MD, FACP, a Little Rock, Ark., internist and geriatrician, became chair of the ACP Board of Regents in April 2006. The term is one year. The Board of Regents is ACP's main policy making body.

Dr. Golden is director of research and projects in the division of general internal medicine at the University of Arkansas for Medical Sciences (UAMS). He is also professor of medicine and public health at UAMS, and is vice president for quality improvement for the Arkansas Foundation for Medical Care.

Dr. Golden has been a member of the ACP Board of Regents since 2000. He is chair of the ACP delegation to the AMA House of Delegates, a member of the ACP Performance Measures Subcommittee, and chaired the ACP Ethics and Human Rights Committee from 2001 to 2005. He has been a Fellow (FACP) of ACP since 1987.

Dr. Golden is a member of the Practicing Physicians Advisory Committee for the National Committee on Quality Assurance, and served as president of the American Health Quality Association from 1997 to 2000. He was on the board of directors of the National Quality Forum from 2000 to 2004 and chaired its Research and Quality Improvement Council from 2000 to 2004. He also has been a methodologist for the Physician Consortium for Performance Improvement since its inception. From 1999 to 2000 he served on the Institute of Medicine's committee on serious or complex medical conditions.

A former president of the American Society of Internal Medicine (1995-1996), Dr. Golden was on the ACP-ASIM Merger Negotiation Committee in 1997, served as ACP-ASIM transitional governor for Arkansas for 1998-2000, and co-chaired the ACP-ASIM Local Merger Subcommittee in 1998. He was also chair of the Federated Council of Internal Medicine for 1996-1997.

Dr. Golden graduated from Baylor College of Medicine and completed his residency at Rush-Presbyterian-St. Luke's Medical Center. He received the Morris Fishbein Fellowship of the *Journal of the American Medical Association* and is a former Robert Wood Johnson clinical scholar.